

JOURNAL of
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Congratulations to the 2009 Maine EMS Award Recipients



L- R: Governor John E. Baldacci, Gary Gardner (Eagle Lake), Tiffany Stebbins (Oakland), Judith Wills (Carrabassett Valley), Arlene Greenleaf (Bethel), Lori Metayer (Board of EMS), Commissioner Brenda Harvey (DHHS), Commissioner Anne Jordan (DPS), Jay Bradshaw (Maine EMS) – missing from photo Chief Les Brown (East Millinocket)



Governor's Award | Maine Health Information Center

L – R: Governor John E. Baldacci, Sandra Johnson, Kelly Goulet, Jeri Kahl, Suanne Singer, Lori Metayer (Board of EMS), Commissioner Brenda Harvey (DHHS), Commissioner Anne Jordan (DPS)



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The EMD Corner

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Everything You Always Wanted to Know About Priority Dispatch (But Were Afraid to Ask)

I'm hoping that the title of this month's EMD Corner catches the eyes of EMS providers, who are becoming increasingly aware of something called priority dispatch, those strange codes being broadcast from communications centers.

For the last six months, Maine EMD Centers have been transitioning to a statewide EMD protocol known as the Medical Priority Dispatch System (MPDS). The MPDS is a medical dispatch system that includes specific "Entry Questions" asked of all 9-1-1 callers requesting medical assistance, follow-up "Key Questions" based upon the caller's chief complaint, post dispatch instructions to guide the caller about steps to take in preparation for EMS' arrival and pre-arrival instructions (PAIs). PAIs are instructions relayed by the emergency medical dispatcher to the caller that provide specific guidance on such things as how to perform CPR, control bleeding, or deliver a baby.

Although Emergency Medical Dispatch on a statewide basis has been required by law since January 2007, three separate protocols have been in use, preventing a consistent statewide system for EMD. Once all EMD Centers transition to the MPDS by 2010, "Determinant Codes" will be used throughout the State to identify the type of call and to facilitate the implementation of priority dispatch. Determinant codes identify the type of call based on chief complaint, the medical severity of a call, and the specific characteristics of the call, and take the form of a number, a letter and a number (i.e., "NN" - "L" - "N"). For example, a call dispatched as a 10 - Charlie - 1 (10-C-1) is a patient complaining of chest pain (Protocol 10 is the MPDS chest pain protocol) with a response level of "C" based upon the results of the EMDs questioning of the caller, and "1", which in Protocol 10 means that the patient is exhibiting abnormal breathing.

Now to the good part, and I mean good in a "send the right response, in the right response mode, in order to improve patient care, make the best use of resources and keep patients, providers and the public safe" sort of way. The good part is priority dispatch—that part of the MPDS that will allow EMS providers to plan responses, improve the quality of patient care and minimize or prevent the hazards inherent in EMS response.

In a nutshell, priority dispatch involves EMS response based upon use of a medical dispatch protocol that results in a determinant code provided to EMS responders by dispatch. The more serious the call, the more immediate and timely the response; the less serious the call, the less the need to respond "hot" (i.e., lights and siren). By send-

ing the right resource, in the right response mode, we can make better use of our EMS providers by tailoring the response to the need, not "sending the cavalry" on every call. And by minimizing the use of "hot responses", we can decrease the likelihood of EMS vehicle accidents and patient/provider/public injuries and deaths. Priority dispatch will be a big change in the way EMS responds to calls; a change that is long overdue.


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The greatest misconception in the EMS community is that dispatchers will be telling field EMS providers how to respond to a medical emergency. Not True! EMS providers, administrators and physicians, (not EMDs) will make the decision on how to respond to a particular call by pre-planning responses according to determinant code. For example, a six-echo-one (6-E-1) determinant code means that the person in need meets the MPDS' definition of ineffective breathing. The EMS preplan for a six-echo-one may include ambulance response running lights and siren, along with ALS backup and response by police with an AED - sending the cavalry, if you will. In contrast, a call for a sprained ankle in a person who is conscious, alert, and not seriously bleeding would receive a thirty - alpha - one (30-A-1) determinant code, which may be pre-planned with a BLS ambulance responding without lights and siren.

To help field personnel decipher determinant codes, Priority Dispatch Inc has a Field Responders Guide for use by EMS that lists the codes and their meanings.

"So" you ask, "when are we going to start using priority dispatch? Our dispatch center is using determinant codes when they dispatch; should we be modifying our response based upon the codes?" The answers to both questions are "In the future" and "No" respectively.

continued on next page



The goal of the campaign is to raise \$50,000.

Kick In Your Spare Change To Raise A Memorial Maine EMS Memorial Fundraising Campaign

The first in a series of fund-raising events to help build an EMS memorial will kick off July 1 and run until September 30. The goal of the campaign is to raise \$50,000.

All Maine EMS services and providers are asked to collect spare change and put it in the EMS Memorial Fund collection container at their respective services. At the end of the campaign, the collection containers will be returned to appropriate regional EMS office. The EMS offices will account for the donations and deposit them in the EMS Memorial Fund. The final tally will be announced at the MidCoast EMS Conference in November.

If your service would like to participate, call or email your regional

EMS office and request a collection container. Each service is asked to designate an "EMS Memorial Champion" to encourage contributions and be responsible for getting the money to the regional office. All participating services will be recognized.

Individual donation containers are also available at the regional offices. These are great for deployment at offices, home, or even in vehicles.

The coins that accumulate from drive thru coffee and fast food windows, those pennies that sit on the bureau, or in a desk drawer, even the change under the couch cushions . . . it all adds up.

Kick in your spare change and help raise a memorial!

Priority Dispatch

continued from previous page

Before we can implement priority dispatch in Maine, we need to ensure that emergency medical dispatchers are using the MPDS and using it correctly. The only way we can be assured of (EMD) protocol compliance is through a robust quality assurance/quality improvement program used in every licensed EMD Center in Maine. As a system, we need to know that the protocol is being used as it was designed, that a high level of protocol compliance is present at EMD Centers, and that emergency medical dispatchers are using the MPDS and using it correctly. Only when the Centers' Quality Assurance/Quality Improvement (QA/QI) programs demonstrate compliance with the MPDS can the EMS system move forward with priority dispatch.

As I write this article, EMD QA/QI managers are receiving training in priority dispatch's QA/QI program, known as EMD-Q. Once trained, the managers will return to their EMD Centers and begin implementation of the QA/QI program. Emergency Medical Dispatchers will receive important, timely and consistent feedback that will help them improve their knowledge, skills and application of the MPDS. Centers will also report QA/QI data to Maine EMS for system evaluation and improvement. The QA/QI effort at all levels will im-

prove and ensure the EMD protocol compliance necessary to implement priority dispatch.

In the coming months, Maine EMS will be developing an educational program for EMS providers about emergency medical dispatch and priority response (there are some emergency medical dispatchers who have already started reaching out to EMS providers with introductory training). EMD Centers will continue to transition to the MPDS and QA/QI will begin to report baseline and ongoing data. Discussions will take place at the local, regional and State levels on how to make priority dispatch a part of EMS practice in Maine. It will take time, patience and cooperation to bring about priority dispatch in Maine, but the effort will be worth it as we make the Maine EMS system better and safer for patients, providers and the public.

For more information on the MPDS, visit the websites of the National Academies of Emergency Dispatch (NAED) at www.emergencydispatch.org and Priority Dispatch Inc. at <http://www.prioritydispatch.net>. For information on Maine dispatch and EMD visit www.maine911.com and www.maine.gov/dps/ems

Enjoy your summer.

Pediatric Water Safety

With summer upon us, the time has come to enjoy the various water activities Maine has to offer. Children are often involved in these events. A statement released by Houston's Texas Hospital for Children says "that about 385 children drown or nearly drown each day, with the majority of those incidents occurring between Memorial Day and Labor Day. About 70% of the preschoolers who drowned last year were being supervised by one or more adults when the incident occurred." Dr Joan Shook, chief of emergency medicine at that hospital is quoted in the same article as saying "In many of the drownings we see, the parent or caretaker was distracted by something seemingly important...and as a result, the child was left alone in the bay, lake, pool, or bathtub. By the time the child was found, a significant amount of time had elapsed."¹

Dr Shook goes on to say that she does not believe teaching children to swim at an early age is a helpful way to avoid tragedy. "Developmentally, children are not prepared for the elaborate coordination required to swim until close to age five, about the time they learn to ride a bike." Her recommendations are that parents never leave their kids alone near any size body of water from an ocean to a bucket. Children between 5 and 12 should be taught to swim and the proper safety rules for pools and beaches. They should use appropriate flotation devices and be taught to use caution when jumping or diving into water. She also recommends that parents learn CPR, as "the likelihood of permanent disability increases for every second a child is not breathing, so while parents are waiting for EMS, they should begin CPR."¹

The U.S. Army Corps of Engineers has issued a list of recommendations for children and water safety. They include:

- a. Wear a life jacket.
- b. Learn to swim. Ask your parents for swimming lessons.
- c. Never go near the water without your parents or someone else who can swim.
- d. Always swim in a safe area, a place that was made for swimming.
- e. Never dive into any lake or river. Tree stumps, rocks, and floating logs can cause serious injury or death.
- f. Don't push or jump on others.
- g. Never pretend that you are drowning.

The National Safe Kids Campaign also has a similar check list that further elaborates by noting that inner tubes and "water wings" are not safety devices and to always wear a U.S. Coast Guard approved life

jacket when in or near an open body of water. This prints off as a great handout for educational purposes.

Kids Don't Float is a program that was started by Safe Kids; Homer, Alaska, coalition. The Kid's Don't Float program provides lifejackets for boaters and swimmers on loaner boards near docks and other open water access sites, as well as an educational component for kids in local schools. This program has grown to more than 400 sites across Alaska, with 12 documented children's lives saved. The Safe Kids website offers information about this program and a program for parents about keeping their children safe around water.



Safe Kids notes that "drowning deaths among children ages 14 and under increase 89 percent in the summer...with 64 percent of all children's drowning occurring in the summer months..."⁴ Based on these statistics, your EMS organization should consider developing a water safety class for parents and children in your service area. If you are unable to offer a class, consider developing water safety materials to hand out, should you or your coworkers ever find yourself in a teachable moment. Increased safety awareness around the water may be the difference in whether a child has a good day at the beach or doesn't come home from the beach.

Credits:

- 1 <http://www.parent.net/article/archives/swimsafe.shtml>
- 2 <http://www.saw.usace.army.mil/jhkerr/kids.htm>
- 3 www.safekids.org
- 4 <http://www.usa.safekids.org/water>

CEH Corner

Once you have finished reading and understanding this issue's article on Pediatric Water Safety, complete the questions below and forward your answers by mail or electronically to MEMS Journal, Jan Brinkman, Education and Training Coordinator, Maine EMS, 45 Commerce Drive, Suite 1, 152 State House Station, Augusta, ME 04333-0152 or jan.brinkman@maine.gov. Your name and license number will be submitted to Maine EMS for credit and will appear directly on your MEMS CEH Report. Your completed questions must be received no later than August 31, 2009 to receive your 0.5 hour in Cat 2 BLS Topics 0.5 hour in Cat 4 ALS Topics

NAME _____

EMS or EMD License Number _____

1. At what age does Dr Shook recommend that children be taught to swim?

2. According to Safe Kids, what percent of children's drowning occur in the summer months?

3. Does Safe Kids recognize "water wings" and inner tubes as approved flotation devices for children?

4. How many documented children's lives have been saved due to the Kids Don't Float program in Alaska?

5. The Houston Texas Children's Hospital estimates what percentage of preschoolers drown while being supervised by an adult?

Therapeutic Hypothermia in the Pre-Hospital Setting

Pete Tilney DO, CC-EMT-P and Kevin Kendall MD, FACEP

Therapeutic Hypothermia has been a “hot” topic recently both in EMS and in Emergency Departments throughout the country in the last several years. This treatment has been adopted widely and is becoming the standard of care for the treatment of cardiac arrest with subsequent return of spontaneous circulation (ROSC). The problem, however, lies in the fact that many providers working in the community have learned bits and pieces about this treatment modality, but are generally unfamiliar with the indications and in fact, the reasons why it should be implemented. In this short article, therapeutic hypothermia will be defined, a brief examination of the literature will be reviewed, and the actual treatment modality will be explained. This article summarizes an enormous amount of work, research and experience that has been conducted on this topic. At the end of this summary, there will be a short list of references that can provide the reader with more in depth information¹.

Historically, the use of “cold remedies” has been used for centuries. Hippocrates advocated for the application of snow and ice to stop bleeding. Soldiers under the command of Napoleon were found to have better outcomes if they became hypothermic after receiving their injuries in battle. In the 19th century, Russian physicians even advocated for the use of “snow burial” and then would hope that after “awhile” patients would wake up and act appropriately.

It was not until the last fifty years, that studies began to examine in earnest the use of hypothermia in certain patient populations. In the late 1950's and early 1960's, a flurry of papers were written examining the role of hypothermia in relation to brain injury and cardiac arrest. At that time, the cooling methods were crude and the results were interesting, but inconclusive. The “father” of pulmonary and critical care medicine, Dr. Peter Safar at the University of Pittsburgh, began working on this project². It was not until 1987 when his group found that if done correctly, canines would have better neurologic outcomes after induced cardiac arrests if they were cooled during and after the cardiac arrest (The question remains, of course, how do you assess that?). Significant research continued in this field for the next 15 to 20 years without significant results^{3,4}. The issue at hand is that physiologically and theoretically, therapeutic hypothermia makes sense, it was just a matter of time before someone could do it in such a way that long term outcomes were significantly beneficial.

As we know, based on our high school Anatomy and Physiology classes, when the heart stops in cardiac arrest, humans become unconscious soon after. The chemical energy, ATP (adenosine triphosphate),

that supplies both our heart and brain is used up. This immediately leads to a sequence of detrimental events including loss of the sodium / potassium gradient in cells, the production of free radicals, and ultimately, if not corrected leads to cellular death. Therapeutic hypothermia mitigates these effects. The theory is that if you cool a person for a certain amount of time, one will decrease the overall metabolic demand, suppress free radical formation, protect cellular membrane, and minimize the inflammatory response that subsequently leads to the sequella that we, as providers, see in the field and hospital as multi-organ failure and brain injury. The brain is exquisitely sensitive to hypoxia and is the first organ affected by this significant change at the cellular level. By cooling the patient, one is essentially limiting the metabolic demand of the cells in the brain thus limiting the production of neurotoxic transmitters leading to cellular death.

Research has continued to demonstrate that the use of Therapeutic Hypothermia (TH) decreases the severity of anoxic brain injuries in patients suffering from cardiac arrests. There is now a significant body of literature that supports its use in hospitals, both in the community and at large tertiary centers, and demonstrates significant improvement in a significant population. A key study out of Australia in 2002 showed that in a V-Fib arrest reversal, patients who were cooled, almost half of them (49%) had favorable outcomes compared to the control group of normothermic patients who had a 26% favorable outcome⁶. Since that initial study published in the New England Journal of Medicine, there have been many studies that have continued to show beneficial results in a variety of settings and by different types of providers^{7,8}.

In terms of pre-hospital induction of therapeutic hypothermia, an article in the Journal of Circulation, the author examined whether cooling patients by EMS in the field was a feasible and effective therapy. In the 2007 paper published by Kim et al, those patients who were randomized to cooling received 2 liters of normal saline. They had an average decrease in body temperature and had improved survivability than those who were not cooled. The team also found that EMS services were able to implement the cooling successfully, and there were no consequences to their actions¹⁰. At this time, the National Association of EMS Physicians (NAEMSP) has not endorsed TH as a treatment modality to be used as a “stand alone” protocol, but has left the “door open” in

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Therapeutic Hypothermia

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the fact that if it is implemented by an EMS program, it must be in conjunction with a hospital program that will continue the cooling and subsequent treatment.

Having determined that in both theory and in practicality, therapeutic hypothermia increases survivability and improves overall outcomes, one must ask the question of how we do it and what is the exact role of pre-hospital providers in TH management. The role of EMS, both ground and helicopter EMS (HEMS), should be early identification, notification, and implementation of their current Prehospital protocols. Not all successful resuscitations are going to respond to active cooling. It is the job of the providers to assess both the inclusion and exclusion criteria of this patient population. Currently, many centers have implemented successful TH protocols that are based on similar criteria. As a rule, inclusion criteria require the patient to be between the ages of 18 and 85, have a VF or VT arrest (this one is important), have a GCS of less than 8, and have a systolic BP of greater than 90mmHg. Patients who have a concurrent illness (including sepsis, terminal disease and a previous coagulopathy), are hypotensive despite additional pressors, trauma patients, or patients who are pregnant are generally excluded.

Once the appropriate patient population has been identified, they must be presented to providers who are able to establish a definitive airway and begin appropriate long term sedation. Some programs advocate the use of benzodiazepines and paralytics while others use propofol. In general, it is important to have adequate sedation during the cooling period. Patients will then be cooled to a target temperature of 32-34 degrees Celsius for approximately 24 hours. A variety of methods can be used ranging from cold IV fluids to ice packs to commercially available products (Arctic sun or bear hugger). The goal is to have a consistent temperature for the entire cooling period. At the conclusion of this period, the patient is allowed to warm up, sedation is weaned, and the neurologic assessment begins.

There are controversies brewing currently. Many of which have to do with what centers are cooling, how is cooling done, what patients are cooled, and what happens if the patients are "overcooled." "Despite these relatively few arguments, therapeutic hypothermia is rapidly becoming the standard of care in a variety of hospitals ranging from small community settings to the largest regionalized trauma centers¹². Research has demonstrated that despite these concerns, there have been no directed adverse outcomes associated directly with therapeutic hypothermia¹¹.

Currently, our job as ground EMS providers is to quickly identify the appropriate patients based upon the above mentioned criteria and alert the receiving facilities accordingly. Once these patients have been selected, the process can begin as soon as feasibly possible by the participating emergency departments and critical care units throughout the state. Hospitals have realized that this is a relatively low capital cost, high yield initiative that can directly affect a group of patients who were previously thought to have persistently poor outcomes.

Note: While this is a frequent topic in many medical journals recently, Therapeutic Hypothermia has NOT been approved for use by EMS providers in Maine at this time.

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From the I/C News editor...

Greetings all!

Change is hard, even positive change. It's especially hard when it involves giving up something you love. I've been through many changes over the years, changes which got me into EMS, and which are now moving me out of it. I've just accepted a promotion at my (non-EMS-related) company, and it's going to involve working a lot more hours. I've come to realize that it's time for me to move on, to make space in my life for new things, new challenges. But to make space, I have to give up some things that have been part of who I've been for more than 20 years. That's hard. This time of change has caused me to look back over my time in EMS, and I'd like to share some thoughts with you here, one last time.

Each of us has our story about what initially got us into EMS. In my case I was working at a "minor emergency room" at a small community hospital, where we didn't see much more than the most minor injuries. One day as I was driving home a non-helmeted motorcyclist sped by me on a narrow curvy road. It made me wonder what I would do if the driver were to crash and I were to be the first person on the scene. That thought lingered in my mind for weeks, and caused me to contact my town's volunteer EMS service and sign up for an EMT course. Every one of you reading this knows how that changes your life!

Not long after I became an EMT, I taught my first-ever class at my hospital. I really enjoyed putting that class together, but nothing surprised me more than how much I enjoyed actually teaching it. As someone who had always shied away from public speaking, this was a huge change! After teaching a handful of other classes to different audiences, I took an IC class. I liked doing EMS, but I loved teaching. I loved the "aha" moments when students would grasp a difficult concept. I loved watching the most unwilling refresher student become an eager learner. I loved the planning, I loved the execution, I loved everything about it.

It was while I was teaching one of my early licensure classes that a student told me that his crewmates questioned what business I had teaching classes — I was after all, they told my student, "just a Basic." As this wasn't the first time I'd heard the

"just a Basic" criticism, I realized that I couldn't change that perception. I could, however, change my reality, and that's when I made the decision to take a paramedic class. I wasn't so much driven to be a paramedic as I was to be a better, more credible teacher by having an advanced license. And while I knew I would learn a lot more about medicine, I was surprised by how the actual process of being a student again, having to do the homework, take the tests, have my practical skills evaluated by someone with a checklist, also had a great impact on my teaching. I shared some of my experiences as a student in the I/C News as I was going through the course, and suggested that every instructor needs to be a student again every so often, to remind himself or herself of what it's like being on the other side of the desk.

The paramedic experience led also to a change in my nursing life. I left the "minor emergency room" to work in one of Maine's three trauma centers, and I learned and learned and learned some more. And then, many years later, I left the trauma center to go work at a company called Health Dialog, where I've been working as a nurse "health coach" for the past three years, providing telephone triage and teaching our members about their chronic health conditions. This, of course, was yet another huge change as I moved further away from EMS and EMS teaching. So the minor emergency room led me to EMS, which led me into teaching, which led me to paramedic school, which led me to the trauma center, which led me to Health Dialog, and which is ultimately leading me now back out of EMS.

I will miss a lot of things about EMS, but probably nothing more than the people. I've met some of the most amazing, selfless, committed people while I've been involved in EMS. And I will definitely miss the teaching. There will be no more "aha" moments from students to inspire me; I will have to come up with my own "aha" moments.

And I will, perhaps most of all, miss being responsible for the Maine EMS I/C News. I started the newsletter back at the end of 1995 — nearly 14 years ago! It's been great fun and great frustration all rolled into one! As this issue of the Journal goes to press, I am working to find a new editor, someone who will take over and perhaps even take the newsletter to a new level.

Change is hard, but I'm hoping the changes in my life, as well as the changes in the I/C News, will be positive ones. I hope you will all stay in touch. Send me an e-mail occasionally just to say hi and tell me what you're up to.

Learning Opportunities for Students

NMCC's Community Leadership Program Provides Great Learning Opportunities for Students

Daryl Boucher, MS, RN, CCEMT-P, PNCCT

Introduction:

With the approval of the Training Center Approval Process by the MEMS board recently, a key change within the Clinical Behavioral Objectives was the replacement of elective hours with a required Service Learning Project for ALS students. This article will describe briefly Northern Maine Community College's Community Leadership Program and the impact it has had on the education of EMS students. Thanks to Robert Hawkes, Eric Wellman and the SMCC staff for sharing with NMCC the structure of the SMCC leadership program, which has been successful for many years.

For the past three years, Northern Maine Community College's EMS ALS students have been required to complete 10 hours of community or civic leadership per semester. The program is modeled after a similar program developed at SMCC, and was initially designed to meet an accreditation requirement for service learning. Service learning has long been used in traditional college settings to allow students to learn outside of the traditional classroom experience. According to the National Service Learning Clearinghouse (www.servicelearning.org):

Service-learning is a teaching and learning strategy that integrates meaningful community service with instruction and reflection to enrich the learning experience, teach civic responsibility, and strengthen communities. It promotes learning through active participation in service experiences. Service learning:

- Provides structured time for students to reflect by thinking, discussing and/or writing about their service experience
- Provides an opportunity for students to use skills and knowledge in real-life situations
- Extends learning beyond the classroom and into the community
- Fosters a sense of caring for others (as adapted from the National and Community Service Act of 1990)

Program leaders at NMCC recognize that a key responsibility of licensed EMS providers is civic and community involvement. The community leadership project orientation starts with a discussion about professions as compared to occupations. Students learn the components of a profession, and what has held EMS back from being considered one, followed by a discussion about what the future holds. As we strive to make EMS a true

profession, civic and community involvement is one of the important components that must be strengthened during the initial education of our EMS students. A key role of any professional is to give back to the profession to which they belong. Experts agree that for an "occupation to be considered a profession, this giving back is expected to be completely altruistic and without expectation for payment or remuneration of any sort. It is what we owe to belong to the profession." In fact, one of the defining characteristics when comparing a profession to an occupation is the requirement of "supporting the profession through professional involvement."^{*}

Initially, it was hoped that the Community Leadership Program at NMCC would instill in students a sense of confidence and comfort in helping grow and promote EMS to a broader population. We wanted to really *show* students how professionals behave, and what the expectations of the profession were. We have been surprised and frankly amazed at the results. Since its inception, students have donated hundreds of hours at health fairs, elementary and high schools, or job fairs. Some students have become active in state or regional EMS meetings, have assisted in teaching or mentoring new students, or have volunteered to help at Special Olympics or trade conferences. Because the program was developed with loose guidelines regarding which activities count towards leadership time, students have been creative in getting their projects approved. Some have become certified to be examiners at practical exams, while others have developed programs at their church. One student actually volunteered in a dental clinical in a third world country.

Although we knew that we would be providing a positive service for the community by developing this program, we were initially unsure about what impact this would have on the students. Would they see the value of such a program, or would they see it as just one more hoop they had to jump through to complete the course? Recently, at a Special Olympics event, I had the opportunity to witness firsthand the impact of this experience on three EMS students. Though they were assigned to the first aid response team, it quickly became obvious how this experience was impacting them positively. They became cheerleaders for the athletes who overcame tremendous personal challenges to succeed in their selected events. They helped with basic tasks such as helping the athletes dress or don their skis, but little of their activities involved first aid skills. I was expecting them to be disappointed — after all, all new students are anxious to use their newly learned skills. Instead, they observed leadership and organization in action. They learned to appreciate the importance of negotiation in achieving goals. They watched insurance company CEOs and bankers, doctors, nurses, and teachers come



together for a common cause — and then they realized that they were a part of it. One of the students commented that he was ready to volunteer again, and he would no longer complain about the difficulties of struggling through class or with minor setbacks after having seen what he had seen. Though this was just one example of the impact of the program, it told me that the program had absolutely accomplished its main goal: **that the activity would have as much impact on the student as the student had on the activity.**

Of course, we have had some growing pains, and there is always the student who will choose to take the easy path to meet the minimum requirement. However, overall, the experiences gained have been amazing. Equally amazing has been the impact that this has had on the instructors and the instruction process. Community leadership projects are now a common discussion during class or informally during breaks. Students talk about their pending projects as if the projects were their own, because in many cases they are. The faculty are able to see students in a different light, and students who in the past were difficult to engage are now engaged much sooner. Faculty members are eager to watch and evaluate the

students' projects, and students are proud of their work and accomplishments. At the end of the project, students are asked to share their experiences and what they learned and how they think this may help them in their professional practice. Without exception, students see this as the first step in their professional growth, and often comment about how this program will make them better leaders in the field.

The starting point of the program:

Definition of a Profession: An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society.*

**Cruess SR, Johnston S, & Cruess RL. (2004, Winter). "Profession: a working definition for medical educators." Teaching and Learning in Medicine, 16(1), 74-6.*



Mike's Training Moments

Michael James Azevedo, Jr. EMT B; Chief, Carmel Fire & Rescue

The Ambulance Driver

Good afternoon to my many friends working in the State of Maine to better the response and efficiency of the Emergency Medical Services system. By now, many of us have felt the change in economic conditions caused by changes in the national economy. The towns with which I am involved have found deficiencies in revenue, and this has caused selectmen, town managers, and chiefs to have to find creative ways to fund programs, provide training and keep personnel on the street.

My service is no different. I have fourteen licensed EMTs, and they provide response capabilities when they can. Most of these people are working two jobs, either at work, or at home taking care of a family. They attend as much training as they can, and as a service we struggle to meet the required standards of Maine EMS, the Maine Bureau of Labor Standards, and good old common sense. Their dedication to the citizens is the reason I keep doing what I do as chief.

This month I would like to talk about the ambulance driver. It has become too costly to send to an EMT class people who never go on to be licensed as EMTs. This happens for many reasons, such as personal life changes, family changes and job changes. And sometimes they find out they do not have the interest in doing the job. I have a limited budget, and this year I had to make the decision to send four firefighters through the fire academy, and not to fund someone in the EMT class. As a result, I am looking to ambulance drivers to assist in the problem. My hope is that ambulance drivers may go on to be licensed in the future.

As many of you know the ambulance driver does play a very important role in the care and treatment of injured people. I came up with a checklist to make sure that our ambulance drivers are fully trained and qualified prior to allowing them to respond to emergency medical calls with licensed personnel. As many of you have noticed, the EMT is busy treating the patient, but the ambulance driver is busy doing everything else. As the expectations and training levels increase in the emergency medical field today, the only thing that has not increased is time. Here are the requirements of my people prior to letting them drive the ambulance. The ambulance driver:

1.) Must provide a copy of his or her drivers license. This may seem obvious, but make sure the driver has a good license. The li-

cense also provides a picture ID for payroll purposes and other back ground checks that should be done.

- 2.) Must complete a minimum of three ambulance checks. Drivers need to know where everything is and what the proper names of equipment are. Drivers need to know the proper way to check fluids and tires, and whom to notify if a problem is found.
- 3.) Needs to know the correct fueling procedures, and what fuel goes into the truck. He or she needs to know what forms get filled out and where these forms are left.
- 4.) Must complete an Ambulance Vehicle Operations Course. This is required by state law.
- 5.) Must complete a minimum of six hours of supervised driving time on the ambulance around the area.
- 6.) Must complete two hours of supervised driving time at night.
- 7.) Must demonstrate knowledge of the major roads in town, and the ability to read a map, as GPS is not always accurate.
- 8.) Must demonstrate knowledge of the driving privileges as described in Title 29-A. The ambulance driver needs to know what he or she can legally do while driving.
- 9.) Must know and understand the operation of the ambulance, including emergency lighting, sirens, exterior lighting switches, wheel chocks, and other equipment that may be needed on the ambulance. My ambulance has SCBA tanks, so the driver also has to know about these.
- 10.) Must be familiar with using both the front cab radio and the radio in the patient compartment. The driver must have an understanding of radio communications, as on serious calls the driver may be the one calling the hospital.
- 11.) Must understand proper placement of the ambulance on the scene. He or she must know not to park in front of a house that is on fire, as this is very upsetting to the firefighters.
- 12.) Must demonstrate the ability to set up and take down an oxygen tank.
- 13.) Must demonstrate the ability to operate the stretcher, know how to put the blankets on the stretcher, and how to operate the stair chair.

Committee Briefs

Exam Committee

Jacky Vaniotis, RN, NREMT-P, Chair, MEMS Exam Committee

At its April meeting, the Exam Committee completed its analysis of the EMT-Intermediate written exam, the only written exam still maintained by Maine EMS. This was a months-long process to assure the quality of the test.

The committee continues to work on updates to the Exam Administration Manual, and plans to post the finished work online on the MEMS web site as soon as it is done.

Jacky Vaniotis resigned from the Exam Committee, and this leaves her position as chairman vacant. The committee awaits a Board appointment to replace her.

Please feel free to attend any meeting of the Exam Committee, which meets on the fourth Tuesday of each month at 9:30 a.m. As always, we recommend that you contact the MEMS office to make sure a meeting has not been canceled or rescheduled.

Teaching Tips from the Classroom

1) Time and time and again we hear that those students who complete the workbook that goes along with their licensure course text are more successful in their course than those who do not do the workbook. One suggestion instructors might make to their students is that they answer the workbook at end of each chapter on plain paper. Then they can answer it fresh again before the unit test. If they do this second review also on blank paper, they could then use the workbook itself for a big review before the final exam.

2) We know that students have different learning styles, and that some students benefit from writing information down. Some students might find it helpful to outline previously unknown textbook material as they read it through the first time; then make an outline of the outline only with what's still unknown the next time, and keep narrowing it down. Studying for the final exam then requires reviewing only the last outline, as that is the only material that the student still doesn't know.

- 14.) Must know how to fill out all required driving logs, training forms, fuel slips, and equipment left at hospital forms.
- 15.) Should be familiar with each of the local hospitals and the procedures there when the ambulance arrives. Knowing how to get to the hospital is a good thing to know as well.
- 16.) Must complete CPR and first aid training.
- 17.) Must complete HIPAA and bloodborne pathogens training.
- 18.) Must complete fire extinguisher training, as well as training in personal protective equipment.
- 19.) Must participate in three EMS trainings prior to being able to drive.
- 20.) Must drive three times on emergency calls with a trainer.

This checklist allows the new person to know what is expected, and allows trainers to keep track of the progress. I use this checklist in a two-page form where a trainer or experienced EMT may sign each of the checkboxes. After completion of each of these accomplishments, the rescue chief will sign off the form allowing the driver operator to respond solo with EMS personnel on emergency calls.

Please note that each requirement above can easily be made into a training session. Seasoned veterans also need to know how to do each of the skills, especially if they drive the ambulance, so they would benefit as well. Secondly, most are a good review for everyone. These training sessions can be a half hour long or up to several hours long, and you can have fun teaching the skills and practicing.

If you are interested in getting a copy of the form I use, please e-mail me at emtengaze@roadrunner.com. Please put "Ambulance Driving Form" in the subject line.

Until next time, stay safe, and thank you for training to protect the citizens of Maine.



Gems from Jan

Jan Brinkman, RN, EMT-P; Maine EMS Education & Training Coordinator

Many EMS providers receive the continuing education hours (CEHs) that they need for license renewal by attending service level training sessions, an in-state EMS conference, or taking a state or nationally recognized program. Two of the most frequently asked questions I hear from providers are "Has this course been approved for credits?" and/or "How many CEHs is this course approved for?"

The first question is easily answered in one of two ways. You may either call your regional EMS office to ask what CEH classes are available in your area, or you can check their website to view the CEH class offerings. A quick way to link to the regional EMS offices is to go to the Maine EMS website at www.maine.gov/dps/ems. Once on the homepage, you will see a horizontal toolbar just under the Maine EMS logo. Click on "Contact Us" and then scroll down to the bottom of that page and you will see quick links to the six regional offices. Then look for the Education or CEH listings on their website.

Many statewide or nationally recognized courses have been pre-approved by Maine EMS for standardized CEHs. These courses have objectives and curriculums that remain constant from class to class. Examples of standardized courses are: CPR, ACLS, PHTLS, PEPP, and PALS.

If you would like to check to see if a course you have taken, or would like to take, has been pre-approved (and if so, how many CEHs it has been approved for) you can quickly find out by going to the Maine EMS website (www.maine.gov/dps/ems). On the homepage you will see a menu on the left side of the screen. Click on "Resources" and then, when the next screen pops up, click on "Training Materials." Then scroll down the screen until you come to the header "Continuing Education Hours" and look for the bullet item "Standardized CEH Program List – Summary." Here you will find the most current listing of pre-approved courses complete with the breakdown of how many hours in each particular CEH category the course is approved for.

If a course has not been pre-approved by a regional office or Maine EMS, is it possible to see if it could be approved for some CEHs? The answer to this is yes, as long as all the information needed to review the course is sent to Maine EMS for review. Because this is time inten-

sive, providers should submit these review requests at least 30 to 60 days prior to their license renewal date to allow time for review and correspondence back to let the provider know whether or not the course has been approved for Maine EMS CEH's. If you would like to see if a course you will be taking, or have taken, may be approved for CEHs, simply follow the guidelines as described in the Maine EMS Rules – Chapter 8 § 2, (2) (A-G):

Maine EMS may grant continuing education hours for programs offered through professional journals, audio and visual media, teleconferencing and the Internet, or for other educational programs not described in this Chapter. To receive approval the applicant must submit to Maine EMS:

- a. An outline and description of the program, to include program handouts
- b. The name and address of the program sponsor
- c. The names of any EMS agencies granting the program continuing education hours
- d. A contact name and telephone number for attendance verification
- e. A program completion certificate, or equivalent
- f. If applicable, approval from the Continuing Education Coordinating Board for EMS (CECBEMS)
- g. Proof, if the program was not supervised, that the program required, and the applicant successfully completed, a knowledge test in order to receive a program completion certificate

The Education Committee welcomes suggestions for new ideas and programs. The Education Committee meets at 9:30 a.m. on the second Wednesday of each month. All are welcome! Please call the Maine EMS office to confirm the date and time of a meeting before coming. If you cannot attend a meeting, but would like to comment on our projects, please feel free to contact Dan Batsie, Education Committee Chair (dbatsie@emcc.edu) or me (jan.brinkman@maine.gov).

Please submit any materials you would like to have published in the next issue of the I/C News by August 15, 2009 for publication in the October 2009 edition of the Journal of Maine EMS. Submit material to: Jan Brinkman at Jan.Brinkman@maine.gov.



So, What Do You Do These Days?

A finger on the pulse (and other VS) of the EMS system by looking at issues at the state and national levels through the eyes of a former Maine EMS director who gets around more than he sometimes would like to.

Whenever I bump into EMS friends and acquaintances around the state, I invariably get this question. I do appreciate the interest; thing is, I still haven't figured out quite how to answer it.

I always thought my view of my "night job" as a street medic and "day job" as an EMS system builder most accurately portrayed my ideal of working in the system and then being in a position to repair the system

Ironically, back in previous EMS lives I would have no trouble explaining my EMS roles (service chief, regional EMS director, ER director, state EMS director....) to these same colleagues, but I could never do an adequate job for non-EMS people. Reduced to the least common denominator was my daughter's usual explanation to friends: "he's a paramedic but he works in an office". That always sounded like a washed up desk jockey to me. I always thought my view of my "night job" as a street medic and "day job" as an EMS system builder most accurately portrayed my ideal of working in the system and then being in a position to repair the system (and then going back on the truck and seeing if I done good or screwed up the repairs).

What I end up answering "what do you do..." question with these days is most generally that I spend most of my time flying to and attending or speaking at meetings and conferences around the country. When I am not doing that, I work in my home-based office in Hallowell trying to catch up on projects I am usually behind in because one more last minute trip had to get squeezed in. My return address is Gate B9 at Logan.

More specifically, I work for a company in Virginia that serves the National Association of State EMS Officials (NASEMSO). I am a program advisor for that association and also serve as the communications technology advisor for NASEMSO, the National Association of EMTs, the National Association of EMS Physicians (NAEMSP), and the National Association of EMS Educators. In that capacity, I basically find myself the primary representative of the national EMS community in public safety communications venues and issues.

In the latter capacity, I've had the chance to help with a number of cool projects, of potential interest and impact to all of us. Check these out:

Out D____ (Dead) Spot!!

Whether it's the cell phone or radio in the back of your ambulance, unless you are an urban EMS warrior, you no doubt encounter dead spots when you need them least. Then its radio roulette to try to find something...radio, cell, sat, different radio...that will get through.

I have spent a few years working with and monitoring something called the Software Defined Radio (SDR) Forum (www.sdrforum.org) as it has developed applications for public safety. Once upon a time, we had to physically plug a "crystal" into a radio or scanner for each frequency we wanted to receive. Then devices were developed that could be programmed to hit frequencies within a specific limited range. If you need frequencies outside of that range, you had to get another radio. In many EMS systems, we have used VHF frequency radios for most dispatch and hospital communications and UHF radios for EKG telemetry communications. Then we layered on cell, and in some cases satellite, phones and other frequencies in some states. This led to a multiplicity of radios in the back of some ambulances.

Then along came SDR. The theory behind SDR is that radios can be made to sniff the airwaves and select an open, strong frequency and plug the user into that frequency as long as it remains open and strong (technically called "cognitive radio"). Radios can also be nimble enough to switch the users to other frequencies when interference is sensed or when other rules are programmed into the radio. For instance, if satellite frequencies were able to sit in the radio next to VHF frequencies, the radio could automatically choose sat comms when it sensed a VHF dead spot and then switch back to VHF when available because it is programmed to avoid sat comms which may have a per minute user fee. This can all be done with-out the user actually knowing which frequency is being transmitted on. Wouldn't it be cool to just pick up the handset and call "Hospital A" and get through every time without necessarily even knowing or caring which frequency you are on?

So how close are we to this SDR solution? The Public Safety Spectrum Trust, the licensee for a planned nationwide public safety broadband network, has specified that transmitters on the system must operate in both the 700 MHz bandwidth licensed to the Trust and satellite frequencies to give complete nationwide coverage. This may be some years away, but it provides tremendous incentive for satellite communications operators to make sat comms affordable and for equipment manufacturers to marry sat comms and other frequencies in one affordable radio. A new multiband handheld radio, the Thales Liberty,

continued on next page

What do you do

continued from previous page

is being tested by Homeland Security in sites around the country, including at EMS applications. It operates in all modes, with full encryption, and enables multi-agency communications in all the public safety frequency bands (136-174 MHz, 380-520 MHz, 700 MHz, and 800 MHz). The Liberty radio works on current analog systems as well as Project 25 (P25) trunking systems, regardless of frequency range. See: https://secure.thalescomminc.com/newsroom_details.asp?ID=333

Smile, You're on EMS Camera!

Video communications are becoming more prevalent in public safety circles. We are all more aware of the increased presence of security and traffic cameras just about everywhere, as well as police video in robots, helicopters and other applications. The utility of video in EMS settings remains an open question. I have been involved in a couple of projects in this regard. In one, NASEMSO and NAEMSP convened an "expert panel" to look at likely future technology in EMS and what communications needs they would create. While instant and digital still cameras have made their rounds in EMS and many units use them to bring added information to the ED (mostly car crash photos), many get pitched or just gather dust in the back of the ambulance. So too seems to be the case in anticipating video use in the field. Some emergency physicians, medics and others see some use for video in enhancing diagnostic capabilities of the online medical director, while others don't believe that the value-added is great enough. Systems which have tried video for this purpose have similarly had mixed results. Without medic buy in the systems don't work. In a number of cases, medics have felt the video equipment and process to be at best one more thing to deal with and at worst invasive to their practice.

One place that video shows promise is for community paramedicine applications. In these settings, medics provide primary care when not on EMS calls (see yet another of my projects *The Rural and Frontier EMS Agenda for the Future*; pp13-14, 81; <http://www.citmt.org/download/rfemsagenda.pdf>). This gives a community added services that it might not otherwise have (like a paramedic and additional primary care) and gives medics clinical practice in rural and other settings where call volume is low. Community paramedics receive training in primary care, but are not untended (in the US anyway) to be independent practitioners. So, when they go out into the field to make house calls, for instance, video may be an important link to their supervising practitioner back in the rural clinic or ED.

A related Homeland Security project in which I am involved is developing standards for video quality for public safety. I am one EMS voice in the process trying to get standards that recognize the need

to be able to discern things like skin coloring and other physical signs.

If you have any pictures of real or simulated patients with visible signs that might be useful examples of EMS applications of video (and that can legally be shared), please send them to me at k.mcginis@roadrunner.com. We are assembling a "typical applications" catalog for the project containing such pictures.

Where'd That Patient Go?

Post 9/11, one of the disaster-related products to receive attention was the good old patient disaster tag. Better mouse traps have included Radio Frequency ID and bar-code technologies that allow for electronic patient ID and medical information entry and tracking. Unfortunately, these systems have been bought on local and regional bases with a lot of the Homeland Security funding. Then, when "the big one" hits (or is exercised) bringing together services with different tracking systems and software, they don't talk to one another. Can we say "interoperability"? Apparently not yet.

And so, with these systems not talking, they provide no electronic information flow outward through other providers who encounter patients at intermediate aid stations or the hospital, and they cannot populate electronic patient care reports if such are used in the event. Further, in a major event, patient tracking needs to be done at mobile command posts and emergency operating centers. Ideally, patient tracking information would flow electronically from the various triage staging areas up to these centers and be combined to give a complete picture of the event. This can't happen with the non-talking systems that exist today.

The Homeland Security project I am helping with now is to create standards for patient tracking software so that all software can be made to comply with the standards and then be able to communicate with one another.

One Less Cluster?

How do we ever get anything done at a car crash and not get killed in the process? Think about it. Dispatched to a 10-55 (oh, that's another project....see below), we arrive on the scene, make sure the scene is generally safe and then dive into patient care. Fire arrives at the scene and dives into suppression and extrication. Police arrive at the scene and handle traffic (or is that fire?) and investigation. The wrecker gets there and tows the cars off. The DOT or public works.....do they do anything?

Somehow we, in Maine, usually make the response work and nobody gets killed or injured in secondary crashes. But we can't rest on our fairly healthy statistics because it is just a matter of time before our fairly uncoordinated responses kills one of us. Check out the "struck by" section of the www.respondersafety.com website and become scared. And then take some action.

Two national transportation projects I am now working on involve develo-



Two national transportation projects I am now working on involve developing training standards for public safety responders to car crashes and developing an easy planning guide for public safety chiefs to use to jointly plan traffic incident responses.

-- Kevin McGinnis, MPS, EMT-P
Program Advisor, National Association of State EMS Officials

ping training standards for public safety responders to car crashes and developing an easy planning guide for public safety chiefs to use to jointly plan traffic incident responses.

A few years back I was the EMS guy on a multi-disciplinary team that looked at traffic incident management (TIM) practices in four European Countries. We were impressed especially by the Dutch who have established a national TIM response directive. It mandates that EMS, police, fire, towing providers, and the highway authority all be considered as TIM responders. Regardless of which one arrives first at the scene, they are expected to do the same first things: put their vehicle in a protective "fend-off" position, cone off the space between their vehicle and the incident, put on a high visibility vest, attend to patients (at least basic care and movement to safety), and then further manage traffic safety until all responders are on scene and assume their usual roles. The training and planning projects in which I am involved seek to improve coordinated response across the nation by helping all of us to plan and train locally.

Check out www.respondersafety.com and www.i95coalition.org if you would like to check out some existing planning and training resources for your own service or community.

Plain as the Nose on your Face....

One last project I will mention is the Homeland Security plain language initiative that I have worked on for a couple of years now as the vice chair of the USDHS SafeCom executive committee. This follows on the NIMS plain language communications specification which has proven easier to say than to do. In practice, it just means that there should be no coded substitutions for English in public safety radio and other communications. So, 10 codes and other codes should be gotten rid of. SafeCom has generated a plain language guide to help local agencies with this transition (including convincing holdouts to do it!). It can be downloaded at: <http://www.safecomprogram.gov/NR/rdonlyres/5945AFE3-ADA9-4189-83B0-4D8218D0CA2F/0/Plain-LanguageGuide.pdf>

EMS agencies have been less likely to have been encumbered with 10 codes because the hospital folks with whom we largely communicate don't generally handle radio codes well. On the other hand, many fire departments have been plain language for years as well. There have



been many compelling anecdotal accounts of confusion over different versions of 10 codes causing response problems nationally. So, the trend is clearly away from such codes.

But what is "plain language" anyway? In the national public safety community, this is a source of much discussion these days. Like "common sense", plain language is mostly apparent when you ain't got any. In a mass crowd control situation, a national guardsman and a cop may act quite differently when told to "cover them". When requesting a "tanker" are you expecting American LaFrance or Lockheed Martin? Finally, what is a "rig", "unit", or "bus" by any other name? An ambulance.


So, once we have rid ourselves of pesky codes, we just have to agree on English. No prob.

So long for now!


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Emergency Medical Services for Children

Jan Brinkman, EMCS Coordinator
Kelly Roderick, Chair, EMSC Committee

Did you know that in our great state of Maine we have 318,835 residents under the age of 19, which is 25% of the total population of the state (Census 2000)? In 2007, Maine EMS providers responded to a total of 17,149 calls involving pediatric patients, which represents 7% of the total calls for which EMS was requested. Knowing these simple facts is the reasoning behind Maine's need to educate and equip its providers along with reducing illness and injury to those 300K kids in Maine.

The Emergency Medical Services for Children (EMSC) program is a federal program designed to reduce childhood death and disability due to severe illness and injury. In 2007, the EMSC program provided funds and requested each state to gather information pertaining to pediatric emergency calls and care. Two specific areas of concern were medical direction for pre-hospital providers and pediatric equipment/supplies. In late 2007/early 2008, the Regional EMS offices, in conjunction with Maine EMS, sent out data collection surveys to ambulance services and hospitals statewide. Maine had an outstanding return rate on these surveys. Of the 284 services surveyed, 257 completed the survey and, of the 39 hospitals surveyed, all 39 completed the survey. Thank you to each of you who took the time to complete this task, it was most helpful to our mission of helping our pediatric population. We would like to share with you the results of the survey and also how Maine services compare in relation to the new ACEP equipment guidelines.

On-Line Medical Control:

One of the questions asked in the survey was whether or not, in general, when BLS or ALS providers have a pediatric call and need pediatric-specific on-line medical direction at the scene of an emergency, is it available to them. Answers available on the survey were: always, usually, sometimes, rarely, and never. Preliminary analysis of the data showed that of the 257 services that completed the survey, 91% of BLS services and 78% of ALS services self-reported having on-line pediatric-specific medical direction.

In follow-up discussions it was discovered that this question may have been misinterpreted to mean that pediatric-specific on-line medical direction had to be provided by a pediatrician. For clarification purposes, since Maine does have in place on-line medi-

cal direction provided by emergency department (ED) physicians and/or physician assistants who are trained to treat patients across all age ranges, then EMS providers do in fact have access to on-line pediatric specific medical direction. If necessary, the ED providers have consult services available to them whether it be in-house personnel or from consultants at one of the three trauma centers in the state.

Off-Line Medical Control:

Another question from the survey dealt with off-line pediatric specific medical direction concerns. It asked, in general, when a BLS or ALS service has a pediatric call and needs pediatric-specific off-line medical direction at the scene of an emergency, are there protocols available in the patient care unit or carried by the EMS provider. Answers available on the survey were: always, usually, sometimes, rarely, and never. Preliminary analysis of the data showed that of the 257 services that completed the survey, 95% of BLS services and 97% of ALS services self-reported having off-line pediatric-specific medical direction.

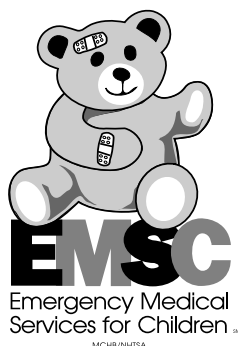
For clarification purposes, since all EMS providers in Maine currently are governed by standardized, statewide protocols, this means that all Maine services have off-line pediatric-specific medical direction.

EQUIPMENT:

This spring, the American College of Emergency Physicians (ACEP) published its guidelines list of supplies and equipment necessary to adequately equip an ambulance to provide the accepted standards of care for pediatric patients. Maine is fortunate that our ambulance service equipment requirement list is fairly comprehensive and meets almost the entire ACEP pediatric equipment guidelines list already.

A couple of exceptions are actually covered in the upcoming Maine EMS Rules proposed changes. These two specifics include adding an infant bag valve mask (ACEP recommends a neonate BVM as well) and an AED (semi-automatic with 2 sets of adult and pediatric pads). Another discrepancy between the two lists is a child size lower extremity traction device. While it was added to this spring's updated ACEP list, the Maine list currently only mandates an adult size traction splint and lists a pediatric traction splint as recommended.

In conclusion, having the right equipment and the right resources (on-line and off-line medical direction) means that we can provide all of our patients with the best pre-hospital care possible. We encourage you to continue working with your local first responding & transporting services, mutual aid services, and hospitals to strengthen the communications on how we can best serve our littlest patients.



A Matter of Trust

The intern's eyes were brimming with tears as she stared at the receiver..." HE wants to talk to you". HE was the cardiologist consultant on call for our 68 year old patient with a clear story of unstable angina. "Hi Joe, Did you have a question?"..."Yeah...I don't know who that was but I couldn't figure out what she was saying". "Hmmm...The patient is Mr. Smith, whom you probably know, with another bout of unstable angina...We've started the nitro and heparin and he's doing better ...just needs to come in. Poor guy can't even move now without getting some chest pain". "OK sure , Why didn't she just say that" Actually she had said that and was very clear in her presentation...but she didn't have the "rank" to pull that off. "Don't worry , HE is like that with all the residents that he doesn't know...I am sorry ..I'll talk to him when he comes down."

I wish this were a story 20 years old, when the hierarchy of medicine seemed more prevalent but unfortunately it was only yesterday. It is a matter of trust..."I don't know you, you probably have had less training than I feel comfortable with and I don't want to allow you to make a decision that diverts me from what I am doing and come to the ED and do your bidding."

There are certainly other strategies consultants use to make life difficult when trying to solicit their help with a patient.... There is the "I don't really want another patient because I am busy now so I will ask for an obscure lab test that should return just as my shift ends"...There is the "bouncing ball gambit"...i.e. "You say there was injury to the great toe during the syncopal episode"..."Has the trauma service seen her?"...Trauma: "Has ortho seen her?...Ortho:...The K is 3.2 has Medicine seen her... etc... There is the "you can handle" it approach: "So yes all you have to do is reanastomose the radial artery after the Z plasty with some vicryl ..give me a call after that and we'll"...yawn..."see where we are."

During their 2nd year our residents take medical control calls. They do get instructions in EMS protocols and have some ambulance ride-alongs to help them understand how to manage patients from the "street" perspective. However, on occasion this seems to be their chance to kick the dog as it were and some of the conversations are painful to listen to: "Yes this is Dr. Jones, how can I help you". "This is East Cupcake Rescue and we have an open femur fracture with a 5 minute ETA and would like to give an additional dose of 100 mc. of fentanyl for pain". "What's the respiratory rate?" "Fine it's 16"."OK...does the patient have any allergies" "Nope we gave him 100 mic already, no problem"... "How's his pain?"..."His femur is sticking out through his

thigh"...big sigh ..."It's bad..""How are his pulses in his foot?"..."They're not great but present" "OK.,What's your ETA, now" ...I'm standing right in back of you Doc!" These guys do indeed know what they are doing...just give the OK for the drug!

Perhaps we can develop a code of conduct for communicating with other health care providers when either consulting or when being the consultant:

I will always be respectful of the consultee's training, knowledge and resources. They are calling to help their patient not to get a run around or hear a lecture.

I will work up the patient to the point where I feel consultation is necessary and further work-up may not be in the best interest of the patient I am treating or other patients that I need to treat. (Consultants walk in the consultee's shoes!)

Everyone's expertise is finite and today's consultant will often be tomorrow's consultee. (This may extend to you someday being the patient in the battle between consultant and consultee... don't go there).

Please add your own assertions!

Meetings of Interest

Emergency Medicine Update

July 20-24, 2009

Colby College, Waterville

18 CME credits in a potpourri of Emergency Medicine topics hosted by Andy Perron of MMC...includes the LLSA course. Great educational for Physician and Midlevel and great fun for the rest of the family. http://www.colby.edu/administration_cs/special_programs/programs/2009/1617900/Emergency-Medicine-Update-with-LLSA-ConCert-training.cfm for more info.

The Maine Mushroom Course

September 18-19, 2009

University of Southern Maine, Portland

8 CME credits in a mixed didactic, field and lab course. Hosted by Tamas Peredy and John Saucier of MMC. Become familiar with the deadly and look-alike delicious fungi of Maine and develop a plan to manage mushroom poisonings in the ED.

FMI: Maine Poison Control Center: http://www.mmc.org/mmc_body.cfm?id=2046

Or 1-800-222-1222

Report of Final Actions

Taken by the Maine EMS Investigations Committee

This notice is written in accordance with direction of the Maine EMS Board that the names, violations, and final disciplinary actions involving licensees who were subject to a fine, suspension, reprimand, requested voluntary surrender, and or revocation of their EMS licenses and or I/C certification be published in the Maine EMS Journal as a public notice.

The information listed in this section reflects the final action(s) taken by the Maine EMS Board. This information does not include pending actions or cases under appeal. This information does not contain, nor does it reflect, all of the factors involved in determining the final action, such as the severity of the misconduct/violation, the licensee's criminal and disciplinary history, or other mitigating factors. This publication is not intended as a guide to the level of disciplinary actions for a particular violation or misconduct, but rather as a publication that will increase awareness, reduce repetitive investigations, identify potential problem areas, and assist in determining areas for improvements in the quality and delivery of EMS statewide.

When your next call involves a hot line — call ours!



Roger Audette, Augusta Fire Department

Don Rowell, CMP Communication Center

Don't take any chances with electricity. If you are first on the scene of an accident involving power lines, **remember:**

- **Assume all electrical wires are live.** Don't touch them or anything that might be in contact with a live wire.
- **Secure the scene.** Keep bystanders and other personnel at a safe distance. A high voltage line on the ground can deliver a fatal shock up to several feet away.
- **Call our CMP hot line.** 24 hours a day, we're ready to dispatch crews to make it safe for you to do your work.

Keeping you safe is a priority for us. Your service is invaluable. We hope ours is, too.



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2009

Name: Scott Newton (EMS # 21828)

Violation: Conviction for Operation Under the Influence; Maine EMS Rules Chapter 11 §(1)(2) and (5).

Action: Mr. Newton agreed to revise the Consent Agreement presently in place as follows: 1) To accept the voluntary surrender of his current EMT-Basic EMS license through its expiration date of October 31, 2009 and 2) To terminate the Consent Agreement (as revised and amended) on October 31, 2009.

Date: March 4, 2009

Name: Caribou Fire (EMS # 135)

Violation: Service allowed an unlicensed provider to respond on its behalf, Maine EMS Rules Chapter 11 § (1)(34) and 32 M.R.S.A. §82(1).

Action: Caribou Fire entered into a Consent Agreement which imposed the following: 1) A reprimand; 2) The service shall develop a policy preventing providers from responding on the service's behalf; 3) The service shall pay a fine of \$100.00 per violation for a total of \$800.00. All but \$100.00 of the fine amount shall be suspended based on the mitigating factors and 4) The service shall submit to Maine EMS an affidavit which states that the service has reviewed its billing records for those eight calls, make any necessary corrections to reflect the unlicensed provider's billing status and certifies that these calls were billed in accordance with state and federal laws.

Date: March 4, 2009

Name: Aurora Volunteer Fire Department (EMS # 854)

Violation: Service allowed an unlicensed provider to respond on its behalf, Maine EMS Rules Chapter 11 § (1)(34) and 32 M.R.S.A. §82(1).

Action: Aurora Volunteer Fire Department entered into a Consent Agreement which imposed the following: 1) A reprimand; 2) The service shall develop a policy preventing providers from responding on the service's behalf; 3) The service shall pay a fine of \$100.00 per violation for a total of \$300.00. All but \$50.00 of the fine amount shall be suspended based on the mitigating factors.

Date: March 4, 2009

Name: Floyd Lawrence (EMS # 18984)

Violation: Practicing EMS patient care without a valid EMS license; Maine EMS Rules Chapter 11§(1)(30) and 32 M.R.S.A. §82(1)

Action: Mr. Lawrence entered into a consent agreement which imposed the following:

1) A reprimand and 2) A fine of \$50.00 per violation for a total of \$200.00. All but \$50.00 of that fine amount shall be suspended based on the mitigating factors.

Date: March 4, 2009

Meet the MMC Emergency Medicine Interns

Casey Z. MacVane, MD

With my class poised to graduate and disperse around the country to various emergency departments (EDs), I thought it was an appropriate time to introduce the new faces that you will be seeing in the MMC ED. Six of the eight incoming interns rotated in the MMC ED as medical students so you may recognize some of them. For the first time in 3 years we again have an equal number of men and women and as usual the interns represent all regions of the United States.

Elizabeth (Betsy) Buyers is from upstate New York. She attended both college and medical school in this area but is drawn to Maine as her husband is from Yarmouth. Betsy spent a month in the ED last summer and we're excited to have her back. She joins the many ED residents with experience with triathalons.

Liisa Clark is moving from "the other Portland" (Oregon), but is familiar with Portland after spending last November in the MMC ED. Liisa has spent a great deal of time doing international work and will bring this interesting perspective to the MMC family.

Ariel Clark is the one native Mainer in the group. She attended college at Colgate in New York and has been at University of Vermont for medical school, but is now returning home. She is interested in rural health care and also rotated in the MMC ED.

Chris Eixenberger is moving to Maine from Nebraska, where he is in medical school. He attended college in Montana. He rotated at MMC and returns to Portland. Chris is an avid skier and has also worked internationally.

John (Jack) Nicolet is well known to the MMC ED family. Jack attended the University of Vermont and did most of his rotations at MMC. He is best known for his wife, Kim who is one of our superstar ED nurses. Jack has a significant background in EMS and wilderness medicine and plans to continue to pursue these interests. Jack has a son Charlie and one on the way.

Elizabeth (Liz) Pierson is from Vermont and attended both college and medical school there. She also has done many rotations at MMC and has been interested in moving to Portland for a long time. She has already begun doing research with MMC faculty members. Liz moves here with her husband.

Thomas Quimby is moving to Maine without having spent time in our ED. He attended college in Alaska and medical school in Seattle. He has worked as a fire jumper and in the forest service. He has a strong interest in rock and ice climbing.

Michael Roehlk is also new to our ED. He grew up and is currently at medical school in New Mexico. His connection to New England occurred while he attended college in Massachusetts. He has traveled in Guatemala and speaks Spanish.

We are excited to work with this class and know you will enjoy getting to know them as well. They will join the already established EMS teams associated with South Portland, Scarborough, Falmouth, Westbrook, Standish and Gorham and spend three years getting to know these EMS providers well. Look for them as you continue to bring us interesting and challenging patients.

Remembering Each Sacrifice Honoring Each Contribution

More than \$20,000 has already been raised for the Maine EMS Memorial planned to be constructed next to the fire and law enforcement memorials next to the capitol on State Street in Augusta, but more donations are needed to meet the \$300,000 goal.

**For more information on how to donate,
visit www.kvems.org.**

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MEMSRR Update & Tips

Jon Powers, NREMT-P; Data and Preparedness Coordinator

Over the past couple months the Maine EMS Run Reporting (MEMSRR) system has seen a number of changes. One of the biggest changes that has taken place, mostly at the state level, has been the addition of our new licensing program. The program was designed by ImageTrend, the same folks that designed the MEMSRR. This new system will now add staff directly to the MEMSRR when they are added to your services roster. With this feature you will start to see more complete user profiles in the staff section including certification numbers and expiration dates. This information will be especially helpful for providers who have upgraded their license. Because the program is new to MEMS, it is taking a few extra days to process new licenses, license upgrades, or renewals. Please be patient with us as we get familiar with the new program. For a faster response you can now check the staff member profile to see if the upgrade has taken effect.

To access this information:

- Login to the MEMSRR.
- From the menu on the left, click on "Staff".
- Click on the name you are looking for in the roster on the right. The information will be on the summary page under Certification Information.

Name:
First Name: Jonathan
Middle Name: D.
Last Name: Powers

Certification Information:
State: ME
Certification ID: 10000
Certification Date: 01/23/2009
Expiration Date: 01/31/2012
Certification Level: EMT-Paramedic
Agency: 2009
Certification Level: EMT-Paramedic
Certification Date: 01/01/2009
Primary Role: Primary Patient Caregiver

Career Information:
Total Length of Service (years): 1
Date Documented: 02/26/2009

Employment Information:
Personnel ID: 10000
Badge #: 00
Position: EMT-Paramedic
Employment Status: Part Time Paid and Part Time Unpaid
Primary Contact: Yes
Medical Director: No
Inspector: No

Contact Information:
Street Address: 100 North Street, Suite 2
Lewiston, ME 04203
Cell Phone: 207-875-1000
Work Phone: 207-828-3881
E-mail: jon.n.powers@maine.gov

Stations:

Buttons: Back to Staff List, Edit

In the coming months service chiefs will have access to a number of online features provided in the new licensing program including staff modifications, service license renewals and vehicle licenses. In the meantime, if you need to make any staff changes, please contact me by e-mail at jon.n.powers@maine.gov

Added features in FieldBridge Version 4.1

For those services using FieldBridge Version 4.1 or for services considering the upgrade to Version 4.1, the feature to create service specific templates has been added. This favored feature from version 3.8 is now

available under "Manage FieldBridge Options" on the MEMSRR. All administration for FieldBridge Version 4.1 is done from this menu.

To access: (For Service Administration Only)

- Login to the MEMSRR
- From the menu on the left, click on "Service Setup"
- In the upper right corner, select "Manage Field Bridge Options" from the "I want to" box.

View Service Info (I want to: Select from the following: Manage Stations, Manage Vehicles, Manage Service Defined Questions, View Statistical Year Information, Manage Field Bridge Options, Repeat Patient Administration)

Service:
Agency ID: 2009
FID: 10000
Site Name: Maine EMS Testing Service

Organizational Information:
Organizational Type: Governmental, Non-Fire
Organizational Status: Non-Volunteer
Primary Type of Service: Rescue
Other Type of Service: 911 Response (Scene) with Transport Capability
Highest Cert. Level of Service: EMT Paramedic

Address:
152 State House Station
Augusta, ME 04333

Contact Information:
Phone: 207-626-3881
Fax: 207-627-3426
Email: jon.n.powers@maine.gov

Emergency Contact Information:
Contact: Jonathan Powers
Type: Email
Address: jon.n.powers@maine.gov

- Finally click on "Launch FieldBridge Layout Editor"

Step by step instructions on how to create these templates are available on the MEMSRR message board and in the knowledge base.

Check user permissions...

Just a reminder for service chiefs and service administrators to review your staff lists and permission groups regularly. In an effort to maintain information security, it is important that your users have appropriate access. One common area where we are seeing this is with billing agents and service QA/QI. If you are using a 3rd party billing service, we don't know when billing agents change, so please check with that agency to assure these folks still require access to your data. This should be done at least quarterly. You may also have providers on your service that at one time were filling the task of QA/QI. Be sure that if they no longer require this level of permission, access be appropriately changed. It is a HIPAA standard that they only have access to protected health information for calls with which they were involved with unless they are part of the system QA/QI or higher on the chain of information processing.

Forget your password??

For those calls when folks just can not remember their password, there is help available. On the login page for MEMSRR you will now notice the "Forgot Password" link in red. If your e-mail address is entered in the staff profile you can use this new feature (if you provide an e-mail address on any new applications this will be added to your profile for you by the licensing program).

To use this feature:

- Click on the "Forgot Password" link.

- In the pop-up box enter the same e-mail address that is in your user profile.
- Finally check your e-mail for a message from Maine EMS providing you your username and password.

You should check your profile to see if you have an e-mail address available or check to be sure it is a current e-mail address that you have access to from any computer such as a gmail, yahoo, or hotmail e-mail account. Many internet service providers (ISP) provide web access to your e-mail as well. If you are not sure how to access it you should contact your ISP's technical support for assistance.

To add an e-mail address:

- Login to MEMSRR
- From the menu on the left, click on "Staff"
- Locate and click on your name from the roster on the right.
- At the bottom of that screen, click on "Edit".
- The E-Mail field is located under Contact Information on the "Demographics" page. This page opens directly after you click "Edit".
- After you add/edit your e-mail address or confirm the current address is correct, click "OK" at the bottom of the page to save your changes.

No Runs to Report

In the past, services that did not have any runs to report in a month submitted a report to the Maine Health Information Center. This is still necessary in the MEMSRR. Please continue to provide this by the 1st of the following month.

For service chiefs to report "No Runs"

- Login to MEMSRR
- From the menu on the left, click on "Inbox"
- Click on the create message icon.
- In the message window, change the "Message Type" to "No Runs"
- In the "Subject" line, type in your service name & number
- In the "Message" field, type a message stating the months you have no runs to report. i.e. if reporting no runs for April simply type in "No runs to report in April"
- Finally, under "Administrative Contacts" click on the MEMSRR contact and click "Submit" at the bottom.

If you have any questions on these changes or about any part of the MEMSRR please contact me either by phone at 626-3861 or by e-mail at jon.n.powers@maine.gov.



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Published quarterly for the Maine Emergency Nurses Association, the Regional EMS Councils, Maine Chapter of the American College of Emergency Physicians, Maine Committee on Trauma, Maine Ambulance Association and the State of Maine EMS

MAINE EMS TEAM LEADERS

Ever wondered who to call when you have a question, complaint, concern or compliment about your EMS system? Listed below are the members of the Maine EMS Board, Maine EMS Staff, and the Regional Coordinators and Medical Directors. Each and every EMS team member in Maine is encouraged to get involved with how your system is run. So get involved—give us a call!

Maine EMS Board Members

Southern Maine EMS Rep	Ron Jones, EMT-P	23 Sterling Drive, Westbrook, ME 04092	TEL: 854-0654
Kennebec Valley EMS Rep	Tim Beals, EMT-P	PO Box 747, Waterville, ME 04903	TEL: 872-4000
Aroostook EMS Rep	Percy Thibeau, EMT-P	229 US Rt. 1, Frenchville, ME 04745	TEL: 543-6697
Tri-County EMS Rep	Lori Metayer, RN, EMT-P	3 Woodland Avenue, Lisbon Falls, ME 04252	TEL: 353-4546
Northeastern EMS Rep	Paul Knowlton, EMT-P	274 Pearl Street, Bangor, ME 04401	TEL: 941-5100
Mid-Coast EMS Rep	Steven E. Leach, EMT-P	PO Box 894, Union, ME 04862	TEL: 785-2260
Physician Rep	Peter DiPietrantonio, DO	4 Picnic Hill Road, Freeport, ME 04032	TEL: 373-2220
Nurse Rep	Geneva Sides, RN	PO Box 287, St. Albans, ME 04971	TEL: 487-5141 x269
First Responder Service	Richard Doughty, EMT-P	4153 Union Street, Levant, ME 04456	TEL: 941-5900
Emergency Medical Dispatch	James E. Ryan, Jr.	62 Main Trail, Hampden, ME 04444	TEL: 570-3773
For Profit Service	Joseph Conley, EMT-P	11 Deer Hill Avenue, Standish, ME 04084	TEL: 252-3947
Not For Profit Service	Bob Hand, EMT-P	100 Hill Street, So. Paris, ME 04281	TEL: 890-6350
State Medical Control Director	Steven E. Diaz, MD	Maine EMS, 152 State House Station, Augusta, ME 04333	
Hospital Rep	Judy Gerrish, RN	891 West Main Street, Suite 400, Dover-Foxcroft, ME 04426	TEL: 564-4207
Municipal EMS Service Rep	Wayne Werts, EMT-P, Chief	Auburn Fire Department, 550 Minot Avenue, Auburn, ME 04210	TEL: 783-6931
Fire Chief Rep	Roy Woods, Chief	Caribou Fire Department	TEL: 493-4204
Public Rep	VACANT		
Public Rep	Ken Albert, Esq., RN	12 South Ridge Lane, Lewiston, ME	TEL: 777-5200

Maine EMS State Office Staff

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Regional Coordinators and Medical Directors

REGION 1	Donnell Carroll, Southern Maine EMS Council 496 Ocean Street, South Portland, ME 04106 TEL: 741-2790 FAX: 741-2158 smems@smems.org	Dr. Anthony Bock, Medical Director
REGION 2	Joanne LeBrun, Tri-County EMS Council 300 Main Street, Lewiston, ME 04240 TEL: 795-2880 FAX: 753-7280 lebrunj@cmhc.org	Dr. Kevin Kendall, Medical Director
REGION 3	Rick Petrie, EMT-P, KVEMS Council 71 Halifax Street, Winslow, ME 04901 TEL: 877-0936 FAX: 872-2753 office@kvems.org	Dr. Tim Pieh, Medical Director
REGION 4	Rick Petrie, EMT-P, Northeastern Maine EMS EMCC, 354 Hogan Road, Bangor, ME 04401 TEL: 974-4880 FAX: 974-4879 neems@emcc.org	Dr. Jonnathan Busko, Medical Director
REGION 5	Steve Corbin, Aroostook Maine EMS 111 High Street, Caribou, ME 04736 TEL: 492-1624 FAX: 492-0342 aems@mfx.net	Dr. Peter Goth, Medical Director
REGION 6	Bill Zito, Mid-Coast EMS Thompson Community Center Routes 131 and 17, PO Box 610, Union, ME 04862 TEL: 785-5000 FAX: 785-5002 office@midcoastems.org	Dr. Colin Coor, Medical Director